

PSYCHIATRIC MEDICAL REPORT
P-142P REV. 5-2001

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
MEDICAL REVIEW DIVISION
On The Web At <http://dmvct.org>



TO: Department of Motor Vehicles, Medical Review Division, 60 State Street, Wethersfield, CT 06161-2510

PATIENT'S NAME	DATE OF BIRTH	TELEPHONE NO.
ADDRESS		WHEN WAS PATIENT LAST EXAMINED BY YOU?
ARE THERE ANY DISORDERS SUGGESTING IMPAIRMENT OF PERCEPTION, ATTENTION, CONCENTRATION, JUDGMENT, HALLUCINATIONS, DELUSIONAL THINKING, USE OF MEDICATIONS, OR DRUGS WHICH MIGHT INTERFERE WITH THE SAFE OPERATION OF A MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO (Please Explain)		

MEDICATIONS (Please indicate dosage)	<input type="checkbox"/> ANTIDEPRESSANTS <input type="checkbox"/> NEUROLYTICS	<input type="checkbox"/> ANXIOLYTICS <input type="checkbox"/> SEDATIVES	<input type="checkbox"/> MOOD STABILIZERS <input type="checkbox"/> ANTABUSE	<input type="checkbox"/> METHADONE <input type="checkbox"/> NALTREXAN (Trexan)	
DOES PATIENT CURRENTLY SUFFER FROM CONVULSIVE SEIZURES?	<input type="checkbox"/> YES <input type="checkbox"/> NO	GIVE DATE OF LAST EPISODE	MONTH	YEAR	TYPE
DO YOU BELIEVE PATIENT UNDERSTANDS THE SIGNIFICANCE OF HIS/HER DISORDER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU BELIEVE PATIENT IS COMPLIANT IN USE OF PRESCRIBED PRESCRIPTIONS?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU HAVE REASON TO SUSPECT THE PATIENT ABUSES ALCOHOL, MEDICATIONS, OR ILLICIT DRUGS?					<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YOUR REPLY IS AFFIRMATIVE TO THE QUESTION ABOVE, (Please elaborate briefly.)					

OF WHAT OTHER RELEVANT MEDICAL, SURGICAL, OR PSYCHIATRIC HISTORY ARE YOU AWARE? (Use additional sheet of paper if necessary)

Does this person have a deteriorating condition? ☐ YES ☐ NO If yes, specify condition and indicate how often he/she should be re-examined.

What is your opinion about this person's ability to operate a motor vehicle safely? Under what circumstances may he/she do so? (Please elaborate.)

DOES THE PATIENT ACKNOWLEDGE EVER HAVING HAD ANY MOTOR VEHICLE ACCIDENTS? ☐ YES ☐ NO

IF YES TO QUESTION ABOVE, WHEN DID THESE ACCIDENTS OCCUR?

TO YOUR KNOWLEDGE, HAS PATIENT EVER HAD A LICENSE DENIED OR REVOKED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YEAR	STATE	REASON
If you do not wish to give your opinion, do you recommend an independent evaluation of this person's fitness to drive by a psychiatrist, or other medical specialist(s)?				

PHYSICIAN'S NAME (Please Print or Type)		OFFICE ADDRESS (Include Zip Code)	
TELEPHONE NO.	PHYSICIAN'S LICENSE NO.	PHYSICIAN'S SPECIALTY	
PHYSICIAN'S SIGNATURE X			DATE REPORT COMPLETED